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July 21, 2006

FILE COPY

Michelle Tomlinson, Administrator
Good Samaritan Assisted Living
840 E Elva St
Idaho Falls, ID 83401-2899

Dear Ms. Tomlinson:

On July 10, 2006, a complaint investigation survey was conducted at Good Samaritan Assisted Living. The survey was conducted by Patrick Hendrickson, R.N. and Polly Watt-Geier, LSW and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00001417

Allegation #1: The facility did not have a behavior management plan in place for a resident.

Findings: Based on interview and record review it was determined the facility did not have a behavior management plan in place for the identified resident.

Review of the identified resident's closed record on July 10, 2006revealed the resident was admitted on Januay 11, 2006 with diagnoses which included cardio pulmonary disease, bipolar disorder and a history of chrohn's disease.

The identified resident's record contained progress notes which documented the following behaviors:

On January 27, 2006, 11:05 a.m., the resident came out of her room naked.

On January 30, 2006, February 1, 2006, February 4, 2006, February 19, 2006, the resident was suspected of smoking in her room.

On May5, 2006, May 15, 2006, the resident yelled at a caregiver.

On May 16, 2006 at 3:00 p.m., the resident drank grape juice from the pitcher on the table.

On May 17, 2006 at 10:00 a.m., caregivers reported the resident came out of her room undressed, yelled at staff, was happy one minute and angry the next. The resident also told a caregiver that she had not been taking her medications and had been hiding them.

On May 17, 2006 at 12:00 p.m., the resident stated "I want to die".

Further review of the identified resident's record revealed no documented evidence of a behavior management plan.

On July 10, 2006at 4:15 p.m., the facility RN confirmed the facility had no behavior management plan for the identified resident. She stated the identified resident had manipulative behaviors. She also stated the staff used interventions such as re-directing, re-assuring, spending one on one time, and distractions to help manage the resident's behaviors. Additionally, the RN stated the resident had not been taking her medications and she expressed a desire to die, she had the resident taken to the emergency room for an evaluation. Subsequently, the resident was discharged from the facility.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by providing interventions to reduce the resident's behaviors. Additionally, the facility had been issued a special waiver and was not endangering the health and safety of the resident.

Allegation #2: The facility did not provide needed supervision to a resident.

Findings: Based on interview and record review it could not be determined the facility did not provide needed supervision to the identified resident.

Review of the identified resident's closed record on July 10, 2006 revealed the resident was admitted on Januay 11, 2006 with diagnoses which included cardio pulmonary disease, bipolar disorder and a history of chrohn's disease.

Further review of the identified resident's record revealed a Uniformed Assessment Instrument (UAI) dated January 18, 2006. Under the supervision section it documented the resident needed minimal supervision and needed behavior re-direction at times.

On July 10, 2006 at 4:15 p.m., the facility RN stated the resident needed frequent re-direction and re-assurance from staff. She stated the resident was accompanied outside by staff when she smoked and staff checked on her frequently throughout the

day. She stated she was highly involved with the resident's care needs and often visited with her daily.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on July 10, 2006.

Allegation #3: A resident has a diagnosis of dementia and eloped from the facility.

Findings: Based on interview and record review it could not be determined the identified resident eloped from the facility or that she had a diagnosis of dementia prior to discharge from facility.

Review of the identified resident's closed record on July 10, 2006revealed the resident was admitted on Januay 11, 2006 with diagnoses which included cardio pulmonary disease, bipolar disorder and a history of chrohn's disease.

Further review of the identified resident's record revealed no documented evidence of the resident eloping from the facility.

On July 10, 2006 at 4:15 p.m., the facility RN stated she was not aware of a time when the resident had eloped from the facility. She stated the resident did go out in front of the building to smoke, but staff always accompanied her to ensure her safety.

On July 10, 2006 at 4:35 p.m., the facility manager stated she was not aware of a time when the resident had eloped from the facility. She stated the resident would smoke outside in front of the facility and staff would usually sit outside with her during those times.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on July 10, 2006.

Allegation #4: A resident was admitted to the hospital with bruising on both arms and a cut on her lip.

Findings: Based on interview and record review it was determined the resident was admitted to the hospital with bruising on both arms and a cut on her lip.

Review of the resident's closed record on July 10, 2006 revealed a "Transfer Assessment" from the hospital dated May 10, 2006. It documented the resident had bruising to her arms, scratches to her forehead, and bilateral lower extremities discoloration.

The resident's record also contained a progress note dated May 10, 2006 at 3:00 p.m., which documented the resident had a reaction to morphine. It also documented

the resident had multiple scratches and bruising due to intravenous therapy and an allergic reaction to morphine.

On July 10, 2006 at 4:15 p.m., the facility RN stated when the resident was admitted to the hospital, she was given morphine and had an allergic reaction. She stated when the resident returned to the facility from the hospital she had bruising from the intravenous therapy and hives from a allergic reaction to the morphine. She also stated the resident's lips cracked and the caregivers put Vaseline on her lip.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by monitoring the bruising and the cut on the identified resident's lip. Additionally, the facility has been issued a special waiver and was not endangering the health and safety of the resident.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Pat Redmond RN
Per Polly Watt-Geier
POLLY WATT-GEIER
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/slc

c: Jamie Simpson, BS, QRMP, MBA, Supervisor, Residential Community Care Program